Revised 10/99

TENNESSEE DIVISION OF MENTAL RETARDATION SERVICES
APPLICATION FOR SERVICES

Applicant Information:

Name:_____ **Date of Birth**: ____/____/____

first, middle initial, last

Social Security #: ___-___-____ **Medicaid #**:_____ **Medicare #**:_____

Other Health Insurance: *(specify)* _____

Race: *(please check)*
☐ White ☐ Black/African American ☐ Hispanic ☐ American Indian ☐ Asian/ Pacific Islander ☐ Other (specify): _____

Gender: *(please check)* ☐ male ☐ female

Address:_____ **Phone**: (____) ___-_____
street

_____ **Zip**:_____ **County**: _____
city, state

Financial Resources: ☐ SSI ☐ SSA ☐ Veterans ☐ Wages ☐ Other (specify):_____

Primary Contact Information:

Name: _____ **Phone**: *home*(___) ___-____; *work*(___) ___-____

Relationship: *(please check)*
☐ Parent ☐ Conservator ☐ Guardian ☐ Sibling ☐ Other relative ☐ Friend ☐ Other _____

Address: _____
street city, state, zip

Current Living Situation:

With whom does the applicant live? *(please check)*
☐ Parent's home ☐ Relative's home ☐ ICFMR ☐ Out-of-state ☐ Nursing facility
☐ DCS foster home ☐ Boarding home ☐ Mental Health Institute ☐ Other psychiatric hospital ☐ Other *(specify)*: _____

Who is the applicant's primary caregiver(s)? _____

What is the caregiver's relationship with the applicant? *(please check all that apply)*
☐ Parent ☐ Conservator/ ☐ Brother/ ☐ Other ☐ Friend ☐ Other (specify):

guardian sister relative _____

What is the age range of the caregiver(s)? ☐ 40 years or less ☐ 41 - 50 years old ☐ 51 – 60 years old ☐ 61 - 70 years old ☐ 71+ years

Does the caregiver work outside of the home? ☐ Yes ☐ No

If there are two caregivers, do both work outside of the home? ☐ Yes ☐ No

What are the work schedules?_____

In general, the caregiver's overall health is: *(please check)* ☐ Good ☐ Fair ☐ Poor

Is there anything right now that makes it difficult for the caregiver to serve in this role? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Information About the Applicant:

Does the applicant have mental retardation? ☐ Yes ☐ No

Does the applicant have other disabilities? _____

IQ Level: _____ **Adaptive Behavior Level:** _____

Approximate date of last psychological evaluation and where completed: _____

_____

Where does the applicant spend his or her day? *(please check)*
☐ At home ☐ At school ☐ At work ☐ At day program ☐ Other (specify):_____

Name of school/work/day program: _____

Can the applicant remain alone at home without the caregiver? ☐ Yes ☐ No

If yes, for how long?_____

Can the applicant go out into the neighborhood or community by himself/herself? ☐ Yes ☐ No

Are there any friends or relatives (besides the caregiver) who stay overnight with the applicant? ☐ Yes ☐ No

Are there any friends or relatives (besides the caregiver) who stay with the applicant for short periods during the day? ☐ Yes ☐ No

Are there any other supports the applicant and/or caregiver receive? ☐ Yes ☐ No

If yes, please describe: _____

How does the applicant communicate with others? *(please check)*

☐ Speaks clearly ☐ Difficult to understand ☐ Cannot speak, but understands others ☐ Uses gestures to communicate ☐ Uses facial expressions to communicate
☐ Uses sign language ☐ Other (specify): _____

How does the applicant get around? *(please check)*

☐ Walks ☐ Walks with assistance from others ☐ Walks with other supports (e.g., braces, walker, cane) ☐ Uses wheelchair some of the time
☐ Uses wheelchair all of the time ☐ Other (specify): _____

How much assistance does the applicant need during the following personal care activities? *(please check)*

Dressing ☐ Must be done by others ☐ Needs some assistance ☐ Does independently ☐ Other (specify): _____

Bathing ☐ Must be done by others ☐ Needs some assistance ☐ Does independently ☐ Other (specify): _____

Eating ☐ Must be done by others ☐ Needs some assistance ☐ Does independently ☐ Other (specify): _____

Toileting ☐ Must be done by others ☐ Needs some assistance ☐ Does independently ☐ Other (specify): _____

Does the applicant have behaviors that are difficult to deal with? ☐ Yes ☐ No

If yes, please describe:_____

_____

_____

How often does this occur?

_____ per day _____ per week _____ per month other: _____

Health Information:

In general, the applicant's overall health is: *(please check)* ☐ Good ☐ Fair ☐ Poor

Does the applicant have any health problems that are currently being treated by a doctor, nurse, or therapist? ☐ Yes ☐ No

If yes, please describe:_____

_____

_____

_____

_____

If medications are taken, what are they for?_____

_____

_____

Does the applicant need assistance to take medications? ☐ Yes ☐ No

If yes, please describe: _____

Does the applicant have any problems with vision or hearing? ☐ Yes ☐ No

If yes, please describe: _____

Does the applicant need special foods or food prepared in a special way? ☐ Yes ☐ No

If yes, please describe: _____

Does the applicant use any assistive devices or special equipment? *(please check)* ☐ Yes ☐ No

☐ Wheelchair ☐ Walker ☐ Gait belt ☐ Lift ☐ Cane ☐ Feeding Tube
☐ Positioning Equipment ☐ Adaptive utensils ☐ Other(specify): _____

Information About Current Supports and Services

Is the applicant currently receiving services from the Division of Mental Retardation Services? ☐ Yes ☐ No

Please list the services and supports the applicant is <u>currently</u> receiving (including school, day services, residential placement, mental health, early intervention, family support, etc.).

Agency _____ ***Type of Service*** _____

Has the applicant <u>previously</u> received services from any of the following: *(check all that apply)*

☐ Arlington Developmental Center ☐ Clover Bottom Developmental Center ☐ Greene Valley Developmental Center ☐ Private ICF/MR ☐ Private Residential Facility
☐ ICF/SNF(Nursing Home) ☐ DMR State funded residence ☐ Mental Health Facility ☐ Out-of-state

Notes: _____

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Information About Needed Services and Supports

What is the reason for wanting services?_____

_____

_____

_____

_____

_____

_____

_____

_____

(If preferred, the applicant and/or caregiver may attach a written statement describing why services are requested.)

Are there specific services and supports the applicant is interested in receiving? *(If so, describe)*_____

_____

_____

Does the applicant want a job? ☐ Yes ☐ No

Where does the applicant want to live? *(Please check)*

☐ Where he/she lives now but with additional services and supports provided

☐ Some other living situation *(describe)* _____

What is the preferred county of residence? _____

How soon are these services and supports needed? *(Please check)*

☐ Right now ☐ Within the next 12 months ☐ At least after 12 months or more

Does the applicant need someone to come in to the home to help with daily living needs like bathing, dressing, grooming, meal preparation, assistance with medical appointments? ☐ Yes ☐ No

If yes, please indicate assistance needed:_____

_____

Does the applicant need some place to go during the day for training and support in daily living, social, communication, getting a job/employment, self-help and other adaptive skills? ☐ Yes ☐ No

If yes, please indicate what is needed:_____

_____

Does the applicant have a medical condition which requires procedures *(like changing a feeding tube, giving a shot)* to be performed only by a nurse if not done by the caregiver? ☐ Yes ☐ No

If yes, please indicate procedures:_____

_____

Does the applicant have problems with eating and drinking or his or her diet that requires assessment and development of an individual nutritional plan by a licensed dietitian/nutritionist? ☐ Yes ☐ No

If yes, please indicate what is needed: _____

_____

Does the applicant have serious dental problems which, if untreated, may lead to more generalized disease, infection, discomfort, or improper nutrition? ☐ Yes ☐ No

If yes, what kinds of dental services are needed? ☐ Root canal(s) ☐ Extraction(s)
☐ Periodontics ☐ Dentures ☐ Other treatment to relieve pain/infection: _____

Does the applicant need physical therapy, occupational therapy, and/or speech, hearing and language services? ☐ Yes ☐ No

If yes, what therapy(ies) is needed? ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Does the caregiver need relief (or respite - someone else serving as caregiver) on a short term basis to be able to have a break or in case of an emergency? ☐ Yes ☐ No

If yes, is this relief needed for: ☐ A few hours ☐ Overnight

Does the caregiver need help dealing with behaviors of the applicant? ☐ Yes ☐ No

If yes, does the caregiver need help to know what to do when these behaviors happen? ☐ Yes ☐ No

If yes, does the caregiver need someone to be with them to help deal with these behaviors? ☐ Yes ☐ No

Are environmental adaptations needed for the applicant to be able to safely access areas of his/her home? ☐ Yes ☐ No

If yes, what kinds of environmental adaptations may be needed? ☐ Ramps ☐ Grab-bars
☐ Widen doorways ☐ Modify bathroom ☐ Install special electric or plumbing systems ☐ Other: _____

Does the applicant need specialized equipment, supplies, and/or assistive technology to increase his or her ability to perform daily living activities, to communicate, and/or control the environment? ☐ Yes ☐ No

If yes, please indicate the needed equipment/supplies/technology: _____

_____

_____

Signature of person completing form ***Title*** ***Date***

The information that has been provided in this Application for Services is true and accurate. I have been informed about the steps that will be taken next by the Regional Office to process this Application. I understand that being included on the waiting list for services does not guarantee eligibility for Medicaid funded services. I have also been informed that I may contact the Regional Office at any time to update this information should circumstances or needs change.

_____

Signature of applicant/legally responsible person ***Relationship*** ***Date***